TennCare Pharmacy Manual

Version 2.0

This document is intended to be a helpful resource to TennCare Network Pharmacies providing services to TennCare Enrollees. A copy of this document is posted on the SXC website for ease of reference. It is updated regularly with program changes. The version number and date of update is shown on cover page of the manual. The most current version of the manual can be found by following the links at http://tennessee.gov/tenncare/pro-pharmacy.html.

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1.0 Introduction

The Point-of-Sale (POS) system will require pharmacies to submit claims to SXC Health Solutions electronically in the National Council for Prescription Drug Programs (NCPDP) standardized Version 5.1; lower versions will not be accepted. After submission, SXC will respond to the pharmacy provider with information regarding recipient eligibility, TennCare's allowed amount, applicable Prospective Drug Utilization Review (ProDUR) messages, and applicable Rejection messages. ProDUR messages will be returned in the DUR response fields; other important related information will be displayed in the free form message area. It is extremely important that pharmacies display all messages exactly as returned by SXC.

All arrangements with switching companies should be handled directly by the pharmacy with their preferred switching company. Pharmacies must submit claims within 45 days of the date of service.

1.1 TennCare Telephone Numbers

Responsibility	Phone Numbers	Availability
SXC Technical Call Center	866-434-5520	24/7/365
SXC Clinical Call Center	866-434-5524 866-434-5523 (fax)	7:00 am – 9:00 pm M-F CST 9:00 am – 3:00 pm, Sat. CST On-call 24/7/365
Member Initiated Prior Authorization	800- 639-9156	24/7/365
Tennessee Dept. of Human Services	888-298-4130 888-298-4130 (Spanish)	8:00 a.m. – 6:00 p.m., M-F
TennCare Pharmacy Program	888-816-1680 888-298-4130 (fax)	8:00 a.m. – 4:30 p.m., M-F
TennCare Fraud and Abuse Hotline	800-433-3982	24/7/365
SXC Provider Relations	480-362-5227 866-278 2881 (fax)	8:00 am – 5:00 pm M-F CST

2.0 Program Setup

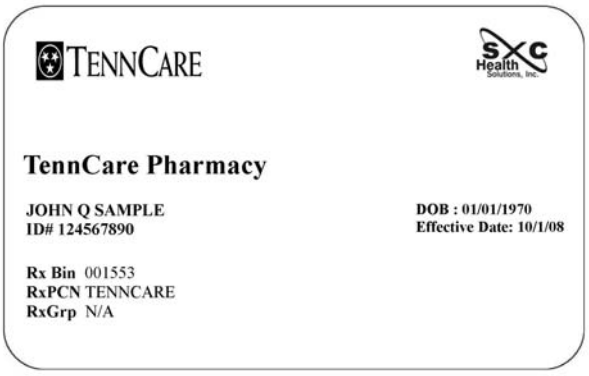
2.1 Claim Submission

- NCPDP version 5.1 format is required for all POS submissions.

The following list provides important identification numbers for this program:

ANSI BIN E	001553
Processor Control #	TENNCARE
Provider ID #	National Provider Identifier
Cardholder ID #	TennCare Pharmacy ID Number or SSN
Prescriber ID #	DEA Provider ID Number or National Provider Identifier
Product Code	National Drug Code (NDC)

- A group number is not needed for a TennCare transaction.
- The TennCare Pharmacy card will list the enrollee's ID number, name and date of birth.
- This patient information must be entered exactly as it appears on the card.
- Do not enter a middle initial.
- The SXC system will also accept the patient's social security number as an alternate ID.



2.2 Timely Filing Limits

Most pharmacies submit point of sale claims at the time of dispensing. However there may be extenuating circumstances that require a claim to be submitted after being dispensed.

For all original claims, reversals and adjustments, the timely filing limit from the date of service (DOS) is 90 days.

- Claims that exceed the prescribed timely filing limit are denied.

  (NCPDP EC #81/Timely Filing Exceeded).
- Providers should contact the TennCare Pharmacy Program at 1-888-816-1680 for late claim override consideration.

3.0 Program requirements

3.1 Dispensing Limits

Days Supply

- There is a per claim day supply maximum of 31 days. Long-term Care providers may dispense up to a 35 days supply.

Dose/Duration

- All claims are interrogated against the Preferred Drug List (PDL), benefit requirements and DUR criteria. A complete listing of prior authorization criteria, step therapy requirement, quantity limits, and duration of therapy edits can be found by following by the links at http://tennessee.gov/tenncare/pro-pharmacy.html.

Dose/Duration

- All claims are interrogated for compliance with state and federal requirements.
- Refill prescriptions must be dispensed pursuant to the orders of the physician, but not more than one year from the DATE Rx WRITTEN (NCPDP field #414-DE).
- **CIIs** (DEA code = “II”) **may not be refilled**; a new prescription is required for each fill.

- **Controlled drugs other than CIIs** (DEA code = “III,” “IV,” “V”) may be refilled, pursuant to the order of the physician, up to five refills (plus one original) or six months, whichever comes first.
- **Non-controlled drugs** (DEA = “0”) may be refilled, pursuant to the order of the physician, up to one year.

3.2 Generic Substitution Policy

TennCare is a mandatory generic program. Should a prescriber indicate that a branded drug is medically necessary for a patient, that prescriber should contact the SXC Health Solutions Clinical Call Center at 1-866-434-5524 to request an exception. TennCare does not allow DAW1 to override the mandatory generic requirement. Without an approved exception, multisource branded drugs are subject to MAC pricing.

Brands for Generic

There is a short list of exceptions to the mandatory generic policy where TennCare prefers a brand product over a generic. For these medications, pharmacies are paid the generic dispensing fee and recipients are not charged a co-pay.

Brand Name		
Novolin R®	Lantus® vials	Copegus®
Novolin N®	Levemir® vials	Lotrel®
Novolin L®	Nexium®	Ventolin® HFA
Novolin 70/30®	Prevacid®	Floxin Otic®
Novolog®	Prilosec OTC®	Trileptal®
Novolog Mix 70/30®	Proscar®	

3.3 Maximum Allowable Cost (MAC) List

- Providers may access information regarding the SXC /TennCare Maximum Allowable Cost by following the links at http://tennessee.gov/tenncare/pro-pharmacy.html. The MAC is updated monthly.

- Providers who have questions or concerns about a particular MAC price may submit a MAC Price Research Request Form.

3.4 COVERED DRUGS

- Legend drug classes are covered with some exceptions.
- Diabetic supplies are covered for recipients.
- DESI/IRS/LTE drugs are not covered.
- Dummy NDCs are not allowed.
- Non-self-administered drugs are not covered through the pharmacy program with some exceptions.
- Drugs excluded from the TennCare Pharmacy benefit include:
  - ❒ Agents when used for anorexia, weight loss, or weight gain
  - ❒ Agents when used to promote fertility
  - ❒ Agents when used for cosmetic purposes or hair growth
  - ❒ Most agents used for the symptomatic relief of cough and colds
  - ❒ Agents when used to promote smoking cessation
  - ❒ Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
  - ❒ Most Nonprescription drugs (See list for Covered OTCs.)
  - ❒ Prescription drugs produced by a manufacturer that is not participating in the Medicaid Drug Rebated program
  - ❒ Barbiturates and benzodiazepines
  - ❒ Agents when used for the treatment of sexual or erectile dysfunction

3.5 Covered OTC Drugs

OTC List for Eligible Children < 21 Years of Age	
Vitamins/Electrolytes	
Biotin Capsules/Tablet	Caffeine Citrate Powder
Calcium Carbonate	Calcium Acetate
Calcium Carbonate With Vitamin D	Calcium Lactate
Folic Acid/Vitamins B Complex With C	Iron Replacement (Selective)
Magnesium Salts	Multivitamins And Multivitamins With Iron
Multivitamins (Prenatal-Pediatric)	Potassium Phosphate (M-Basic, D-Basic)

OTC List for Eligible Children < 21 Years of Age	
Sodium Bicarbonate Tablets	Vitamin A, Bs, B Complex, C, D, E
Cough/Cold	
Abreva® (Docosanol)	Brompheniramine/Pseudoephedrine
Chlorpheniramine	Dextromethorphan
Diphenydramine	Guaifenesin
Guaifenesin DM	Loratadine
Loratadine-D	Pseudoephedrine
Saline Nasal Drops	
Protein Replacement	
Arginine	Levocarnitine Capsule/Tablet
Gastrointestinals	
Aluminum Carbonate Capsule/Suspension	Aluminium Hydroxide Capsule/Tablet/Suspension
Bisacodyl Suppositories/Tablet	Docusate Calcium Capsules
Docusate Sodium Capsule/Liquid/Syrup/Enema	Glycerin Suppositories
Loperamide	Magnesium Hydroxide Suspension
Magnesium Hydroxide/Aluminum Hydroxide	Magnesium Hydroxide/Aluminum Hydroxide/Simethicone
Prilosec OTC	Psyllium Agents
Sorbitol	
Pain/Fever	
Acetaminophen	Aspirin
Buffered Aspirin	Ibuprofen Tablets/Liquid
Naproxen Sodium OTC	
Diabetes	
Alcohol Pads	Blood Glucose Meters
Blood Glucose Test Strips	Glucose Control Solution
Insulins	Pen Needles- Syringe Needles
Lancets	Insulin Syringes
Asthma Supplies	
Spacers	Sodium Chloride (Saline) For Inhalation

Topical Agents and Vaginals	
Ammonium Lactate 5%, 12% Cream, Ointment, Lotion	Bacitracin Zinc
Benzocaine Dental Ointment	Benzocaine Ointment/Cream
Benzoyl Peroxide	Clotrimazole Cream/Ointment/Lotion/Intravaginal (Suppository/Creams)
Diphenydramine Ointment	Hydrocortisone 1% Cream
Ketoconazole 1% Shampoo	Miconazole Cream/Ointment/Lotion/Intravaginal Products
Mineral Oil/Petrolatum Ointment	Permethrin 1% Liquid
Povidone–Iodine Topical Solution	Triple Antibiotic Ointment
Miscellaneous	
Ointments And Drops Used For Eye Lubricants (I.E. Artificial Tears)	Ointments And Drops Used As Saliva Substitutes
Betaine Tablet	Meclizine
Phenylketonuria (PKU) Agents	Sodium Benzoate Powder

For the most recent version of this list, follow the links at http://tennessee.gov/tenncare/pro-pharmacy.html.

OTC List For Eligible Adults 21 Years And Older Who Have Pharmacy Coverage		
Vitamins/Electrolytes		
Calcium Acetate	FA/Vitamin B Complex With C	Prenatal Multivitamins
Antihistamines		
Loratadine	Loratad I N E-D	
Gastrointestinals		
Prilosec OTC		
Diabetes		
: Alcohol Pads	Blood Glucose Meters	
Blood Glucose Test Strips	Glucose Control Solution	
Insulins	Pen Needles	
Lancets	Syringes	
Asthma Supplies:		
Spacers	NACL For Inhalation	
Miscellaneous	PKU (Phenylketonuria Disorder)	

For the most recent version of this list follow the links at http://tennessee.gov/tenncare/pro-pharmacy.html.

3.6 Recipient Co-Pay Information

- TennCare Medicaid children (defined as less than 21) are not subject to co-pays. TennCare Medicaid adults (defined as 21 or older) who have a pharmacy benefit and who are not LTC residents or HCBS waiver recipients are subject to co-pays.
- Exceptions include:
  - ❒ Pregnant women
  - ❒ People receiving hospice care
  - ❒ TennCare Standard Children at or above 100% of the federal poverty level

Note: Pregnant women and people receiving hospice care need to self-declare at the pharmacy in order to be exempt from the co-pay. The pharmacy may override the co-pay for a pregnant recipient by submitting a “2” in the

Pregnancy Indicator field (NCPDP field 335-2C). The pharmacy may override the co-pay for a recipient in hospice care by submitting an “11” in the Patient Location field (NCPDP field 307-C7).

- Brand name medications have a $3.00 co-pay per prescription.
- Generic medications have no co-pay.
- Family planning drugs are not subject to the co-pay.
- The pharmacy system determines the co-pay based on the above eligibility rules.
- Enrollees cannot be denied services for failure to make a co-pay.
- A claim for a multi-ingredient compound receives a brand co-pay.
- In certain circumstances, the TennCare PDL may list only brand name drugs as preferred agents in a drug class in which generic drugs are available. In such cases, the preferred brands are treated like generics in that they do not count toward the two brand per month limit and they do not carry the brand co-pay. See Section 3.2 for a listing.
- Clozaril® and clozapine are subject to co-pay for only the first fill each month.

3.7 Prior Authorization

Technical Call Center Prior Authorizations

The SXC Pharmacy Help Desk handles the following authorization requests on behalf of TennCare:

- For Early Refill Denials, the claims processing system response displays the next fill date. Dose change overrides can be obtained by calling the Technical Call Center.
-

Clinical Call Center

The SXC Clinical Call Center handles the following authorization requests on behalf of TennCare.

- Preferred Drug List (PDL)
- Step Therapy
- Clinical Criteria

- Quantity Limits
- Dose Optimization
- Therapeutic Duplication
- Drug-Drug Interaction
- All Other Clinical Edits

To request prior authorization for the edits listed above, the prescribing physician or the prescribing physician's agent must call the SXC Clinical Call Center at 866-434-5524. Prescribers may also initiate a prior authorization by faxing the appropriate request form to 866-434-5523. Should the pharmacist have access to the applicable clinical information, they may initiate the Prior Authorization request.

- Ideally Prior Authorizations should be obtained at the point the prescription is being written. If this does not occur, the claim is denied at POS with a message that the prescriber should contact 866 434-5524 for prior authorization consideration.
- The SXC Clinical Call Center responds to all prior authorization requests within 24 hours of initiation.
- It is not necessary to enter a PA Number when the claim is transmitted. An active PA record in the SXC system is all that is necessary.
- Prior authorization edits apply to all claims types and claims media.

Pharmacists Responsibilities

Participation in the TennCare pharmacy program requires pharmacists to adhere to specific procedures when unresolved point-of sale denials are encountered. Denials for non-preferred medications, step therapy, therapeutic duplication, and quantity limits are subject to the following requirements of the Grier Consent Decree.

- The pharmacist must attempt to contact the prescriber or SXC Clinical Call Center to resolve the denial.
- If the pharmacist is unable to resolve the denial and dispense the prescription in full, the pharmacist should complete and provide the patient with the Prior Authorization Required Form (PARF).
- The Prior Authorization Required Form (PARF) explains why the patient is not receiving the prescribed medication or full amount and how a patient may help initiate the prior approval process.

- If the pharmacist contacts the prescriber and he/she indicates that a prior authorization will be initiated (but hasn't been obtained yet), the pharmacist should provide the patient with the Prior Authorization Required Form (PARF).
- If the pharmacist is unsuccessful in reaching the prescriber and resolving the matter, the pharmacist should consider providing an emergency three-day supply of the medication in accordance with the procedures listed in the section below.
- Regardless of whether the patient receives an emergency supply, a Prior Authorization Required Form (PARF) must be provided whenever the prescribed medication or the quantity ordered is not received.
- A copy of the Prior Authorization Required Form (PARF) is included in Appendix B. Copies are also available online by following the links at http://tennessee.gov/tenncare/pro-pharmacy.html. or by calling 866-434-5520.
- In addition, the pharmacy is responsible for displaying the Emergency Supply and Appeal Notices (orange and green posters written in English and Spanish) describing TennCare enrollees' right to appeal adverse decisions affecting services and other applicable notices in public areas of their facility in accordance with TennCare rules, including TennCare Rules 1200-13-13-.11 and 1200-13-14-.12. Posters are available at: http://tennessee.gov/sos/rules/1200/1200-13/1200-13.htm.

Appropriate Diagnosis for Prior Authorization Bypass

In an effort assist Prescribers and Providers, Prior Authorization requirements can be bypassed for certain medications when specific medical conditions exist. Those specific medications and diagnoses are noted below. Prescribers are encouraged to include the applicable diagnosis code on written prescriptions for inclusion on the electronic pharmacy claim. The submitted claim should include a Diagnosis Code Qualifier (field 492-WE) of "01," indicating ICD-9, as well as the appropriate Diagnosis Code (field 424-DO)

ICD-9 code prior authorization over-ride for preferred atypical antipsychotics: clozapine, Geodon®, Risperdal®, Seroquel®, Fazaclo®

ICD-9 Code	Diagnosis/Description
295.0 – 295.9	**Schizophrenic Disorders**
296.0 – 296.99	**Episodic Mood Disorders**
297.0 – 301.22	**Delusional Disorders**
292.10 – 299.9	**Other**

The following ICD-9 codes should allow for the authorization into the class for the following agents: Foradil®, Serevent®, Combivent®

ICD-9 Code	Diagnosis/Description
496.0	Chronic Obstructive Pulmonary Disease (COPD) Chronic Obstructive Lung Disease Nonspecific Lung Disease

The following ICD-9 codes should allow for the authorization into the class for the following agents: Sporanox®

ICD-9 Code	Diagnosis	ICD-9 Code	Diagnosis/Description
117.3	Aspergillus	115.0	Infection by Histoplasma capsulatum
116.0	Blastomycosis	115.1	Infection by Histoplasma duboisii
117.5	Cryptococcosis	115.9	Histoplasmosis, unspecified
321.0	Cryptococcal meningitis		

The following ICD-9 codes should allow for the authorization into the class for the following agents: Tracleer®, Revatio® and Ventavis®

ICD-9 Code	Diagnosis/Description
416.0	Primary Pulmonary Hypertension
416.8	Other Chronic Pulmonary Heart Diseases

3.8 Emergency Supply Policy

The TennCare pharmacy program requires pharmacists to adhere to specific procedures when unresolved point-of-sale denials are encountered. Denials for non-preferred medications, step therapy, therapeutic duplication, and quantity limits are subject to the following requirements of the *Grier Consent Decree*: The pharmacist must attempt to contact the prescriber or SXC Clinical Call Center to resolve the denial. If the pharmacist is unsuccessful in reaching the prescriber and resolving the matter, the pharmacist should consider providing an emergency three-day supply of the medication.

An emergency situation is a situation that, in the judgment of the dispensing pharmacist, involves an immediate threat of severe adverse consequences to the enrollee, or the continuation of immediate and severe adverse consequences to the enrollee, if an outpatient drug is not dispensed when a prescription is submitted.

The Emergency Supply Policy does not apply to drugs that are not normally covered by TennCare. Protocol for provider level overrides is as follows:

- **Emergency Supply: Non-PDL Edits** - claim denied for drug being non-preferred or requiring prior authorization.
  - ❒ The pharmacist should determine if an immediate threat of severe adverse consequences exists should the patient not receive an emergency supply.
  - ❒ In the pharmacist's judgment, if the dispensing of an emergency supply is warranted, determine the appropriate amount for a three-day supply. For unbreakable packages, the full package can be dispensed.
  - ❒ Resubmit the adjusted claim to SXC, including both a Prior Authorization Type Code of "8" (NCPDP #461-EU) and Prior Authorization Number NCPDP #462-EV of "88888888888" to override the POS denial.
  - ❒ Should the claim deny despite the inclusion of the proper override code and number, contact the SXC Technical Call Center at 1-866-434-5520 for a review or assistance with claim.
- **Emergency Supply: DUR Edits** – claim denied for Quantity Limit, Drug-Drug Interaction, Therapeutic Duplication, High Dose, etc.
  - ❒ The pharmacist should determine if an immediate threat of severe adverse consequences exists should the patient not receive an emergency supply.
  - ❒ In the pharmacist's judgment, if the dispensing of an emergency supply is warranted, determine the appropriate amount for a three-day supply. For unbreakable packages, the full package can be dispensed.
  - ❒ Should the claim deny despite the inclusion of the proper override code and number, contact the SXC Technical Call Center at 1-866-434-5520 for a review or assistance with claim..
- The enrollee is not charged a co-pay for the emergency supply.
- The emergency supply counts toward the prescription limit.
- Only one emergency supply is provided per prescription per year.

- Recipients are not able to return to the pharmacy for the remainder of the original prescription unless the prescriber has received Prior Authorization.
- This makes it that much more important to try to reach the prescriber in cases where he/she has written for a non-preferred drug, or a drug that is denying because of a clinical edit.
- The dispensing provider has the ultimate decision whether to dispense an emergency supply.

If the prescriber obtains a Prior Authorization (PA) or changes the drug to an alternative not requiring a PA in the same month, the remainder of the prescription and/or substitute prescription does not count toward the limit.

To exempt the remainder of the prescription from the prescription limit once a Prior Authorization is obtained, or to exempt the replacement prescription from counting toward the prescription limit, the value of “5” must be submitted in the Submission Clarification Code (NCPDP field 42Ø-DK) on the incoming claim within 14 days of the initial prescription.

A more detailed review of the Emergency Supply process can be accessed on the web by links at http://tennessee.gov/tenncare/pro-pharmacy.html.

3.9 Prescription Limits

TennCare Medicaid adults (defined as 21 or older) who are not in an institution or Home and Community Based Services (HCBS) waiver are subject to a monthly prescription limit. Exception – as noted above, non-pregnant Medically Needy adult enrollees who are not in an institution or HCBS waiver have no pharmacy benefit.

- Every calendar month the affected enrollees are limited to five prescriptions and/or refills, of which no more than two can be brand names
- TennCare has developed a list of medications, the “Auto-Exemption List” (formerly called the “Short List”), that do not count towards the prescription limit and that continue to be available to the enrollee after the limit has been hit.
- The “Auto-Exemption List” is applicable only to persons who have pharmacy coverage with a monthly limit. Persons without pharmacy coverage may not obtain drugs on this list.
- The pharmacy Point-of-Sale system (POS) recognizes “Auto-Exemption List” drugs and ensures that they are not counted toward the limit.

- The POS system also enables the pharmacist to determine when a claim is denied because of the prescription limit. The rejection is an NCPDP code of 76, “Plan Limitations Exceeded” with a supplemental message of, “Monthly limit of 5 scripts exceeded”. The message that is returned for the third brand script is, “Monthly limit of 2 brand scripts exceeded”.
- Pharmacies may bill enrollees for prescriptions over the prescription limit; however, the pharmacy should always attempt to process the prescription and receive the “over the limit” denial before billing the patient.
- In rare circumstances, the TennCare PDL may list only brand name drugs as preferred agents in a drug class in which generic drugs are available. In such cases, the preferred brands are treated like generics in that they do not count toward the two brand per month limit and they do not carry the brand co-pay. This list is included in Section 3.2 of this document.

Pharmacy Auto-Exemption List	
Antineoplastics	Dialysis Medications
Antiparkinsonian Agent	Flu Vaccine – Injectable formulations only
Anti-tubercular Agents	Hematopoietic Agents
Anti-Virals	Hepatitis C Agents
Asthma Agents	Immunosuppressives
Cardiovascular Disease (Oral Formulations Only)	Iron Preparations
Clotting Factors	Long-acting Antipsychotics
Diabetes Agents – Insulins	Transplant Agents
Diabetes Agents – Oral Hypoglycemics	

A full list is available by following the links at http://tennessee.gov/tenncare/pro-pharmacy.html.

Prescription Limit Override Process

This process allows a TennCare enrollee who is subject to prescription limits to receive prescriptions over and above the monthly limit, i.e., more than five prescriptions or two brand names per month. The complete listing of medications which apply to this override process can be viewed by following the links at http://tennessee.gov/tenncare/pro-pharmacy.html.

Two mechanisms are available to go beyond the five prescription/two brand limit:

- Auto-Exemption List (formerly known as the "Short List"). Medications on this list automatically do not count towards the prescription limit
- Prescriber Attestation List (also known as "Soft Limits"). Patients may access drugs on this list if the prescriber goes through the attestation process described below.

How does the prescriber attestation process work?

- TennCare has already paid for five prescriptions or two brands that month.
- The prescriber determines that an additional prescription is needed to prevent serious health consequences, and the drug in question is not on the Auto-Exemption List (formerly known as the "Short List").
- The drug the prescriber wants TennCare to cover is on the Prescriber Attestation List.
- The **prescriber must** initiate a **telephone** call to TennCare's pharmacy benefit manager, SXC Health Solutions **866-434-5524.**
  - For acute medications, in which no greater than a one-month supply is requested, the **prescriber** must attest that without access to the requested drug, the patient is at high risk for health consequences that are serious enough to result hospitalization, institutionalization or death within the next 90 days.
  - For a drug that may be needed for longer than a one-month period, the prescriber must review the patient's full medication profile with a clinical pharmacist at SXC and subsequently attest that no viable option exists to substitute one of the drugs the patient receives under the prescription limit for the drug for which the special exemption is sought.
- An individualized attestation form is faxed to the prescriber immediately following the telephone call for signature. The form must then be signed and FAXED back to SXC **as soon as possible** to the number provided on the form.
  - Requests for which a signed attestation form is not received **within three days** are closed, and a new request must then be called in.
- The enrollee receives the prescription that helps avert an immediate threat of severe consequences.

Key Points

- Recipients should not exhaust their prescriptions limits on discretionary drugs and then seek Attestation for essential drugs.

- Prescribers should substitute from the Auto-Exemption List whenever possible.
- Prescribers should prescribe combination products and 31 day supplies when appropriate.
- Prescription limit override requests are not considered for medications outside of the classes on the Prescriber Attestation Drug List.
- All Preferred Drug List, step therapy, clinical criteria, and utilization edits/criteria apply.
- The Prescriber Attestation Drug list includes Approximately 500 medications in 20 drug categories.

Prescriber Attestation Drug List		
▪ Antibiotics	▪ Antipsychotics	▪ Nitroglycerin preparations
▪ Antifungals	▪ Anticonvulsants	▪ Antiplatelet agents
▪ Antivirals	▪ Antidepressants	▪ Anticoagulant agents
▪ Ophthalmic preparations	▪ Rheumatoid arthritis agents	▪ Oral Steroids
▪ Respiratory agents	▪ Antiarrythmics	▪ Thyroid hormones
▪ Diabetes	▪ Hypotensives	▪ Multiple Sclerosis Agents
▪ Parkinsons Agents	▪ Otics	

Dose Titration: Relief from Prescription Limit Accumulation

TennCare recognizes that prescribers must frequently tritrate the dosage of a medication to achieve therapeutic goals. This often requires more than one prescription for the same drug in a single month. However, multiple prescriptions used in dose titrations may accumulate against prescription limits. The TennCare Pharmacy Program established a Dose Titration Override process to avoid unnecessary increments to prescriptions limits for select drugs and/or drug classes. Pharmacy providers are allowed to process a second claim for the same medication within 21 days of the initial claim by placing a **"2"** in the Submission Clarification Code field (NCPDP #420-DK). Claims submitted in this manner for the same drug within 21 days of each other do not count toward the prescription limit. Claims for the following drugs and classes can be submitted with a Titration Override Code:

Anticoagulants	warfarin, Jantoven®, Coumadin®
Low Molecular Weight Heparins	Arixtra®, Fragmin®, Lovenox® and Innohep®
Anticonvulsants	phenytoin, Dilantin Infatab®, Dilantin Kapseal® 30mg, Phenytek®, Dilantin-125®, and Dilantin Kapseal®
Xanthines	Theophylline
Selective Serotonin Reuptake Inhibitors (SSRIs)	citalopram, fluoxetine, fluvoxamine, paroxetine, sertraline, Celexa®, Lexapro®, Luvox®, Paxil®, Paxil CR®, Pexeva®, Prozac®, Prozac Weekly®, Sarafem®, and Zoloft®
Selective Norepinephrine Reuptake Inhibitors (SNRIs)	venlafaxine, Effexor XR®, Cymbalta®, and Effexor®
Atypical Antipsychotics	clozapine, FazaClo ODT®, Geodon®, Risperdal®, Seroquel®, Seroquel® XR, Abilify®, Abilify Discmelt®, Clozaril®, Invega®, Risperdal M-Tab®, Risperdal Consta®, Zyprexa®, and Zyprexa Zydis®

3.10 Coordination of Benefits

It is important that Providers are reminded that TennCare is always the payer of last resort. Each TennCare recipient should be questioned whether he/she is covered by any pharmacy insurance provider other than TennCare. Should the recipient identify another pharmacy payer, you are required to bill all other payers prior to billing pharmacy claims to TennCare.

- As a matter of program policy providers must bill all other payers first and then bill TennCare. TennCare is always the payer of last resort.
- If the recipient shows other coverage on the DOS and other payment is received, providers must submit:
  - OTHER COVERAGE CODE (NCPDP #308-C8) = “2” (other coverage exists/payment collected). Other values in this field are not accepted.
  - OTHER PAYER AMOUNT PAID field (NCPDP #431-DV) = amount received from all other payers
  - OTHER PAYER ID field (NCPDP #340-7C) = “88888”
  - OTHER PAYER DATE (NCPDP #443-E8) = date payment received from other payer

- In all cases, SXC Health Solutions uses the TennCare **"Allowed Amount"** when calculating payment. If the primary insurer has reimbursed greater than the TennCare Allowed Amount, this may result in zero payment on the secondary claim.

3.11 Long-Term Care Claims

- TennCare allows up to a 35 day supply per fill.
- Drugs that are generally included as floor stock are not covered if the patient is a resident in a Long-Term Care facility.
- Dispense Fees:
  - $2.50 for brand drugs.
  - $3.00 for generics.
  - $5.00 for brand drugs with days supply greater than or equal to 28 days.
  - $6.00 for generic drugs with days supply greater than or equal to 28 days.
  - There is no repackage fee.
- PA, PDL, and ProDUR edits (as described for retail) apply unless specifically noted otherwise.

3.12 Special Recipient Conditions

- Patients may be locked into a designated pharmacy. In the event of an emergency, SXC may be contacted for override consideration.
- Specific patients may also be subject to Prior Authorization requirements for all controlled substances. Controlled substance claims submitted for these individuals are denied with an NCPDP-75-Prior Authorization Required, the supplemental message reads, "Controlled Drug PA Required." The prescribing physician is required to contact the SXC Clinical Call Center at 1-866-434-5524 to apply for a Prior Authorization to allow payment.

3.13 Compounds

Compound Claims Processing

All compounds must be submitted using the NCPDP v5.1 standard multi-ingredient compound functionality. Therefore, all ingredients must be identified, their units must be indicated, and the ingredient cost for each ingredient must be communicated. At least one item in the compound must be a covered drug. The full Payer Specification Sheet for the TennCare Pharmacy program is included in this manual.

Provider Instructions

- On Claim Segment:
  - Enter PRODUCT CODE/NDC (NCPDP field # 407-D7) as “00000000000” on the claim segment to identify the claim as a multi-ingredient compound.
  - Enter COMPOUND CODE (NCPDP field # 406-D6) of “2”.
  - Enter QUANTITY DISPENSED (NCPDP field # 442-E7) of entire product.
  - Enter INGREDIENT DRUG COST (NCPDP field # 409-D9) of entire product.
    - This must equal the sum of the individual ingredient drug costs submitted in the compound segment.
  - Enter GROSS AMOUNT DUE (NCPDP field # 430-DU) for entire product.
  - Enter USUAL AND CUSTOMARY CHARGE (NCPDP field # 426-DQ) for entire product.
  - SUBMISSION CLARIFICATION CODE (NCPDP field # 420-DK) = 8 (Process Compound for Approved Ingredients) allows a claim to continue processing if at least one ingredient is covered. This is only needed if the compound contains a non-covered ingredient.

- On Compound Segment:
  - COMPOUND DISPENSING UNIT FORM INDICATOR (NCPDP field # 451-EG)
    - Acceptable values are **ML** or **GM**

- COMPOUND ROUTE OF ADMINISTRATION (NCPDP field # 452-EH)
  - Example values are
    - 3 = Inhalation
    - 4 = Injection
    - 11 = Oral
    - 13 = Otic
    - 15 = Rectal
    - 17 = Topical
- COMPOUND INGREDIENT COMPONENT COUNT (NCPDP field # 447- EC) (Maximum of 25), must equal the number of NDCs transmitted in the compound segment
- For each line item (ingredient):
  - COMPOUND PRODUCT ID QUALIFIER (NCPDP field # 488-RE), always **03 = NDC**
  - COMPOUND PRODUCT ID (NCPDP field # 489-TE), **NDC** of ingredient
  - COMPOUND INGREDIENT QUANTITY (NCPDP field # 448-ED), quantity of the individual ingredient included in the compound
  - COMPOUND INGREDIENT DRUG COST (NCPDP field # 449-EE), cost of the individual ingredient included in the compound

Important Notes

- The Claim Segment Product ID (i.e., NDC) is defined as a mandatory field and, therefore, must be submitted for all claims, including multi-ingredient compounds.
- A non-blank space value is expected in this field for field validation. The pharmacy submits all zeroes in this field for a multi-ingredient compound. For compound segment transactions, the claim is rejected if all zeroes are not submitted as the Product ID.
- A Submission Clarification Code value of “8” only allows a claim to continue processing if at least one ingredient is covered. TennCare covers both rebateable and non-rebateable ingredients for compounded claims.
- Each multi-ingredient claim counts as one claim towards the Brand Rx fill limits, if applicable.

- Pharmacies must transmit the same NDC number(s) that is/are being used to dispense the medication.

3.14 Injectable Drugs

Drugs which cannot be self-administered should be billed as a medical benefit to the Managed Care Organization (MCO) by the physician or provider administering the drug.

Claims submitted on behalf of adult ambulatory TennCare patients for products deemed non-self-administered return messaging to the pharmacy through the point-of-sale system (POS) indicating that the product needs to be billed as a medical benefit. Claims are denied and the message returned is, “Medical Benefit: Provider to Bill MCO.” Drugs given intravenously are considered non-self-administered by the patient. Absent evidence to the contrary, drugs given by intramuscular injection may be presumed to be non-self-administered by the patient. Additionally, products whose package literature does not list or support self-administration are included in this POS edit.

There are a number of drug products that are administered by the IM or IV route that, due to established channels of distribution, are not subject to this edit. (See the list of covered injectable drugs in the table below.) In addition, Long-Term Care (LTC) patients, as well as Department of Health Pharmacies, are not subject to the edit. There may be instances where an emergency exists, the provider does not have access to the needed drug, or a caregiver has been trained to administer the drug. In these situations, an override may be requested by calling the SXC Clinical Call Center at 1-866-434-5524 or by faxing the request to 1-866-434-5523.

Covered Injectable Drugs					
Product	**CC***	**Product**	**CC***	**Product**	**CC***
Abilify®	X	Haloperidol Decanoate		Miacalcin®	
Antihemophilic Factors		Heparin		Neulasta®	
Arixtra®		Humira®	X	Neumega®	
Byetta®	X	Interferons, Hepatitis		Neupogen®	
Chlorpromazine		Interferons, Multiple Sclerosis		Octreotide Acetate	
Dihydroergotamine Mesylate		Interferons, Pegylated		Procrit®/Epogen®	X
Enbrel®	X	Imitrex®		Raptiva®	X

Covered Injectable Drugs					
Product	**CC***	**Product**	**CC***	**Product**	**CC***
EpiPen®/EpiPen Jr®		Influenza Vaccines		Risperdal Consta®	X
Flolan®		Innohep®		Somavert®	
Fluphenazine Decanoate		Insulins		Symlin®	X
Forteo®		Leukine®		Synagis®	X
Fragmin®		Leuprolide Acetate		Xolair®	X
Geodon®	X	Lovenox®		Zyprexa®	X
Glucagon		Medroxyprogesterone Acet			
Growth Hormones	X	Methotrexate			
• CC indicates that clinical criteria must be met prior to dispensing					

3.15 Pharmacy Reference Guide

The most current information on the following topics can be found by following the links at http://tennessee.gov/tenncare/pro-pharmacy.html.

TennCare Preferred Drug List
Branded Drugs Classified as Generics
Clinical Criteria, Step therapy, and Quantity Limits for the TennCare PDL
Listing of Covered Injectable Drugs
TennCare Prior Authorization Request Form
Appropriate Diagnosis for Prior Authorization Bypass
TennCare Pharmacy Provider Manual

Pharmacy Override Summary		
Override Type	**Override NCPDP Field**	**Code**
Emergency 3-Day Supply of Non-PDL Product	Prior Authorization Type Code (461-EU)	8
Hospice Patient (Exempt from Co-pay)	Patient Location Field (NCPDP field 307-C7)	11
Pregnant Patient (Exempt from Co-pay)	Pregnancy Indicator Field (NCPDP field 335-2C)	2
Titration Dose Override for the following select drugs/drug classes: clozapine/Cozaril®, Effexor® 225mg (Effexor® XR 75 mg and Effexor® XR 150mg), Cymbalta® 90mg (Cymbalta® 30 mg and Cymbalta® 60 mg) warfarin, low molecular weight heparins, phenytoin, theophylline, Selective Serotonin Reuptake Inhibitors (SSRIs), Selective Norepinephrine Reuptake Inhibitors (SNRIs) and atypical antipsychotics-process second Rx for the same drug within 21 days of initial Rx with an override code to avoid the second Rx counting as another prescription against the limit. Two co-pays will apply.	Submission clarification Code (42Ø-DK)	2

4.0 Prospective Drug Utilization Review (ProDUR)

Prospective Drug Utilization Review (ProDUR) encompasses the detection, evaluation, and counseling components of pre-dispensing drug therapy screening. The ProDUR system of SXC assists the pharmacist in these functions by addressing situations in which potential drug problems may exist. ProDUR performed prior to dispensing helps pharmacists ensure that their patients receive appropriate medications. This is accomplished by providing information to the dispensing pharmacist that may not have been previously available.

Because SXC Health Solutions' ProDUR system examines claims from all participating pharmacies, drugs which interact or are affected by previously dispensed medications can be detected. SXC Health Solutions recognizes that the pharmacist uses his/her

education and professional judgment in all aspects of dispensing. ProDUR is offered as an informational tool to aid the pharmacist in performing his/her professional duties.

4.1 Therapeutic Edits

Therapeutic Duplication

A Therapeutic Duplication edit has been enabled for specific therapeutic classes as a safety precaution. Claims encountering this edit are denied with a NCPDP 88-TD. Additional information is shared as outlined in Section 4.3 below.

Therapeutic Duplication Alert Classes		
ACE Inhibitors	Antipsychotics	H2RAs
ACE Inhibitors/CCB	Benzodiazepines (Anxiety)	Leukotrienes
Alpha Blockers	Benzodiazepines (Insomnia)	Statins (lipotropics)
Angiotensin Receptor Blockers	Beta Blockers	Fibrates (lipotropics)
Antiartritics (NSAIDS, COX-II)	Bile Salt Sequestrants	Narcotic Analgesics
Antidepressants (SSRI, SNRI)	Calcium Channel Blockers	Quinolones
Antidepressants (TCAs)	PPIs	Skeletal Muscle Relaxants
Antihistamines		

Early Refill

Prescriptions can be refilled only after 85% of the days supply has been exhausted. Requests for overrides may be made to the SXC health Solutions Technical Call Center at 1-866-434-5520.

Special Accumulation limits

Hydrocodone 1200 mg per rolling 30 days

Oxycodone 1200 mg per rolling 30 days

Acetaminophen 120 gm per rolling 30 days

4.2 Call Center

SXC Health Solutions' Technical Call Center is available 24 hours per day, seven days a week. The telephone number is 1-866-434-5520. Alert message information is available from the Technical Call Center after the message appears. If you need

assistance with any alert or denial messages, it is important to contact the Technical Call Center about ProDUR messages at the time of dispensing. The Technical Call Center can provide claims information on all error messages, which are sent by the ProDUR system. This information includes: NDCs and drug names of the affected drugs, dates of service, whether the calling pharmacy is the dispensing pharmacy of the conflicting drug, and days supply.

The Technical Call Center is not intended to be used as a clinical consulting service and cannot replace or supplement the professional judgment of the dispensing pharmacist. SXC Health Solutions has used reasonable care to accurately compile ProDUR information. Because each clinical situation is unique, this information is intended for pharmacists to use at their own discretion in the drug therapy management of their patients.

A second level of assistance is available if a provider's question requires a clinical response. To address these situations, SXC staff pharmacists are available for consultation.

ProDUR is an integral part of the TennCare Pharmacy Program's claims adjudication process. ProDUR includes: reviewing claims for therapeutic appropriateness before the medication is dispensed, reviewing the available medical history, focusing on those patients at the highest severity of risk for harmful outcome, and intervening and/or counseling when appropriate.

4.3 ProDUR Alert/Error Messages

All ProDUR alert messages appear at the end of the claims adjudication transmission. Alerts appear in the following format:

Format	Field Definitions
Reason for Service	Up to three characters. Code transmitted to pharmacy when a conflict is detected (e.g., ER, HR, TD, DD).
Severity Index Code	One character. Code indicates how critical a given conflict is.
Other Pharmacy Indicator	One character. Indicates if the dispensing provider also dispensed the first drug in question. 1 = Your Pharmacy 3 = Other Pharmacy
Previous Date of Fill	Eight characters. Indicates previous fill date of conflicting

	drug in YYYY/MM/DD format.
Quantity of Previous Fill	Five characters. Indicates quantity of conflicting drug previously dispensed.
Database Indicator	One character. Indicates source of ProDUR message. 1 = First Data Bank 4 = Processor Developed
Other Prescriber	One character. Indicates the prescriber of conflicting prescription. 0 = No Value 1 = Same Prescriber 2 = Other Prescriber

5.0 Provider Reimbursement

5.1 Ambulatory/LTC Network Pharmacy Payment Algorithms

Pricing is always the “lesser of”:

- AWP – 13% + dispense fee or
- Federal MAC + dispense fee or
- TennCare MAC + dispense fee or
- Usual and Customary or
- Gross Amount Due

Compounds:

- Each individual ingredient is priced as above + the applicable dispense fee. The lesser of calculated amount, Usual and Customary, and Gross Amount Due are reimbursed. There are no additional repackaging fees.

5.2 Ambulatory/LTC Network Pharmacy Dispensing Fees

- Ambulatory:
  - $2.50 for brand drugs
  - $3.00 for generics drugs of MAC.
  - Compound: up to $25.00; antibiotics are not authorized for this amount and pays the standard $2.50 dispense fee.
- Long-Term Care (LTC):
  - $5.00 for brand drugs with days supply greater than or equal to 28 days.
  - $6.00 for generic drugs with days supply greater than or equal to 28 days.

5.3 Specialty Network Pharmacy Dispensing Fees

Pricing is always the “lesser of”:

- Applicable discount rate from the Specialty Pharmaceutical Pricing List
- AWP – 16% + dispense fee or
- Federal MAC + dispense fee or
- MAC + dispense fee or
- Usual and Customary or
- Gross Amount Due

5.4 Specialty Network Pharmacy Payment Algorithms

- ❒ No Dispensing if included in Specialty Pharmaceutical Pricing List
- ❒ $1.50 if not include in Specialty Pharmaceutical Pricing List

5.5 Pharmacy Reimbursement Schedule

- The Payment cycle for both networks beginning on Tuesday at 12:00 a.m. CT and ends on the following at Monday at 11:59:59 p.m. CT.
- Provider reimbursement is issued weekly. Checks and Remittance Advices are mailed on Friday for the most recently completed cycle.

6.0 Payer Specification Sheet

The Bureau of TennCare

310 Great Circle Road
Nashville, TN 37243
888 816 1680

SXC Health Solutions, Inc.
PO Box 3214
Lisle, IL 60532-8214

Bin #: 001553
States: All Participating Pharmacy in the TennCare Program
Destination: SXC Health Solution (RxCLAIM)
Accepting: Claim Billing, Reverse/Rebill/ Reversal, and Eligibility Inquiry
Format: NCPDP Version 5.1 or higher

1. Segment And Field Requirements By Transaction Type

BILLING (B1), REVERSAL (B2), REBILLING (B3), ELIGIBILITY INQUIRY (E1) Transaction Data Elements
(M-Mandatory, S-Situational, ***R-Repeat Field)

Transaction Header Segment – Mandatory			Required
NCPDP Field	**Field Name**	**Mandatory or Situational**	**COMMENTS/VALUES**
101-A1	BIN NUMBER	M	001553
102-A2	VERSION/RELEASE NUMBER	M	51
103-A3	TRANSACTION CODE	M	B1, B2, B3, E1,
104-A4	PROCESSOR CONTROL NUMBER	M	TENNCARE
109-A9	TRANSACTION COUNT	M	01 – 04; One Transaction For B2 Or Compound Claims; Up To 4 For B1 Or B3
202-B2	SERVICE PROVIDER ID QUALIFIER	M	01 (NPI)
201-B1	SERVICE PROVIDER ID	M	National Provider Identifier
401-D1	DATE OF SERVICE	M	CCYYMMDD
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	O	Use Value For Switch's Requirements, Or Populate With Blanks

Patient Segment – Situational			Required for B1, B2, & B3 transactions
NCPDP Field	**Field Name**	**Mandatory or Situational**	**COMMENTS/VALUES**
111-AM	SEGMENT IDENTIFICATION	M	01
331-CX	PATIENT ID QUALIFIER	S	Not Required - Captured if transmitted
332-CY	PATIENT ID	S	Not Required - Captured if transmitted
304-C4	DATE OF BIRTH	S	Not Required - Captured if transmitted
305-C5	PATIENT GENDER CODE	S	Not Required - Captured if transmitted
310-CA	PATIENT FIRST NAME	S	Required fir this program
311-CB	PATIENT LAST NAME	S	Required fir this program
322-CM	PATIENT STREET ADDRESS	S	Not Required - Captured if transmitted
323-CN	PATIENT CITY ADDRESS	S	Not Required - Captured if transmitted
324-CO	PATIENT STATE / PROVINCE ADDRESS	S	Not Required - Captured if transmitted
325-CP	PATIENT ZIP/POSTAL ZONE	S	Not Required - Captured if transmitted
326-CQ	PATIENT PHONE NUMBER	S	Not Required - Captured if transmitted
307-C7	PATIENT LOCATION	S	11 = Hospice, Exempt from Co-Pay
333-CZ	EMPLOYER ID	S	Not Required - Captured if transmitted
334-1C	SMOKER / NON-SMOKER CODE	S	Not Required - Captured if transmitted
335-2C	PREGNANCY INDICATOR	S	2 = Pregnant, Exempt from Co-pay

Insurance Segment – Situational			Required For B1, B3, And E1 Transactions
NCPDP Field	**Field Name**	**Mandatory or Situational**	**COMMENTS/VALUES**
111-AM	SEGMENT IDENTIFICATION	M	04
302-C2	CARDHOLDER ID	M	TennCare Pharmacy ID or SSN
312-CC	CARDHOLDER FIRST NAME	S	Not Required - Captured if transmitted
313-CD	CARDHOLDER LAST NAME	S	Not Required - Captured if transmitted
314-CE	HOME PLAN	S	Not Required - Captured if transmitted
524-FO	PLAN ID	S	Not Required - Captured if transmitted
309-C9	ELIGIBILITY CLARIFICATION CODE	S	Not Required - Captured if transmitted
336-8C	FACILITY ID	S	Not Required - Captured if transmitted
301-C1	GROUP ID	S	Not Required - Captured if transmitted
303-C3	PERSON CODE	S	Not Required - Captured if transmitted
306-C6	PATIENT RELATIONSHIP CODE	S	Not Required - Captured if transmitted

Claim Segment – Mandatory			Required for B1, B2, & B3
NCPDP Field	**Field Name**	**Mandatory or Situational**	**COMMENTS/VALUES**
111-AM	SEGMENT IDENTIFICATION	M	07
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	M	Required 1 = Rx billing
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	M	Required
436-E1	PRODUCT/SERVICE ID QUALIFIER	M	03 = NDC
407-D7	PRODUCT/SERVICE ID	M	11-digit NDC
456-EN	ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER	S	Required when billing for a partial fill
457-EP	ASSOCIATED PRESCRIPTION/SERVICE DATE	S	Required when billing for a partial fill
458-SE	PROCEDURE MODIFIER CODE COUNT	S	Required ONLY if Procedure Modifier Code Submitted
459-ER	PROCEDURE MODIFIER CODE	S	Not Required - Captured if transmitted
442-E7	QUANTITY DISPENSED	S	Required for B1 & B3 transactions
403-D3	FILL NUMBER	S	Required for B1 & B3 transactions 0 = Original dispensing 1-99 = Refill Number
405-D5	DAYS SUPPLY	S	Required for B1 & B3 transactions
406-D6	COMPOUND CODE	S	Required for B1 & B3 transactions 2 = Compound
408-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	S	
414-DE	DATE PRESCRIPTION WRITTEN	S	Required for B1 & B3 transactions
415-DF	NUMBER OF REFILLS AUTHORIZED	S	Not Required – Captured if transmitted
419-DJ	PRESCRIPTION ORIGIN CODE	S	Not Required – Captured if transmitted
420-DK	SUBMISSION CLARIFICATION CODE	S	Not Required – Captured if transmitted
460-ET	QUANTITY PRESCRIBED	S	Required on partial or completion fills
308-C8	OTHER COVERAGE CODE	S	Required for COB transaction
429-DT	UNIT DOSE INDICATOR	S	Required, 3 = Pharmacy Unit Dose
453-EJ	ORIG PRESCRIBED PRODUCT/SERVICE ID QUALIFIER	S	Required on partial or completion fills
445-EA	ORIGINALLY PRESCRIBED PRODUCT/SERVICE CODE	S	Required on partial or completion fills
446-EB	ORIGINALLY PRESCRIBED QUANTITY	S	Required on partial or completion fills
330-CW	ALTERNATE ID	S	Not Required – Captured if transmitted
454-EK	SCHEDULED PRESCRIPTION ID NUMBER	S	Not Required – Captured if transmitted
600-28	UNIT OF MEASURE	R	Required EA=each, GM=grams, ML=milliliters
418-DI	LEVEL OF SERVICE	S	Not Required – Captured if transmitted
461-EU	PRIOR AUTHORIZATION TYPE CODE	S	Required, 8 = 72 Hour Emergency Supply
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED	S	Enter 88888888888 when 8 is submitted in 461-EU
463-EW	INTERMEDIARY AUTHORIZATION TYPE ID	S	Not Required – Captured if transmitted
464-EX	INTERMEDIARY AUTHORIZATION ID	S	Not Required – Captured if transmitted
343-HD	DISPENSING STATUS	S	Required when submitting a partial fill or the completion of a partial fill. Blank = Not Specified, P = Partial Fill, C = Completion of Partial Fill
344-HF	QUANTITY INTENDED TO BE DISPENSED	S	Required on partial or completion fills
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED	S	Required on partial or completion fills

Prescriber Segment – Situational			Required for B1 &, B3 transactions
NCPDP Field	**Field Name**	**Mandatory or Situational**	**COMMENTS/VALUES**
111-AM	SEGMENT IDENTIFICATION	M	03
466-EZ	PRESCRIBER ID QUALIFIER	M	01 = National Provider ID or 12 =DEA
411-DB	PRESCRIBER ID	M	NPI or DEA
467-1E	PRESCRIBER LOCATION CODE	S	Not Required - Captured if transmitted
427-DR	PRESCRIBER LAST NAME	S	Required for this program
498-PM	PRESCRIBER PHONE NUMBER	S	Not Required - Captured if transmitted
468-2E	PRIMARY CARE PROVIDER ID QUALIFIER	S	Not Required - Captured if transmitted
421-DL	PRIMARY CARE PROVIDER ID	S	Not Required - Captured if transmitted
469-H5	PRIMARY CARE PROVIDER LOCATION CODE	S	Not Required - Captured if transmitted
470-4E	PRIMARY CARE PROVIDER LAST NAME	S	Not Required - Captured if transmitted

COB/Other Payments Segment – Situational			Required ONLY for COB processing
NCPDP Field	**Field Name**	**Mandatory or Situational**	**COMMENTS/VALUES**
111-AM	SEGMENT IDENTIFICATION	M	05
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	M	Required if Segment is Used Maximum = 3
338-5C	OTHER PAYER COVERAGE TYPE	M***R***	01 = Primary 02 = Secondary 03 = Tertiary 99 = Composite
339-6C	OTHER PAYER ID QUALIFIER	S***R***	Required Blank = Not Specified 01 = National Payer ID 02 = Health Industry Number (HIN) 03 = Bank Information Number (BIN) 04 = National Association of Insurance Commissioners (NAIC) 09 = Coupon 99 = Other
340-7C	OTHER PAYER ID	S***R***	Required, Other Payer ID must = 88888 if Segment is Used
443-E8	OTHER PAYER DATE	S***R***	Required, CCYYMMDD
341-HB	OTHER PAYER AMOUNT PAID COUNT	S	Required if Segment is Used
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	S***R***	Blank = Not Specified 01 = Delivery 02 = Shipping 03 = Postage 04 = Administrative 05 = Incentive 06 = Cognitive Service 07 = Drug Benefit 08 = Sum of all reimbursement 98 = Coupon 99 = Other
431-DV	OTHER PAYER AMOUNT PAID	S***R***	Required if Segment is Used
471-5E	OTHER PAYER REJECT COUNT	S	Not Required - Captured if transmitted
472-6E	OTHER PAYER REJECT CODE	S***R***	Not Required - Captured if transmitted

DUR/PPS Segment – Situational			Segment is Not Required, use encouraged if applicable
NCPDP Field	**Field Name**	**Mandatory or Situational**	**COMMENTS/VALUES**
111-AM	SEGMENT IDENTIFICATION	M	08
473-7E	DUR/PPS CODE COUNTER	S***R***	Required if segment used, one to 9 occurrences are supported
439-E4	REASON FOR SERVICE CODE	S***R***	Required when needed to communicate DUR information. See “ProDUR” section in Provider Manual.
440-E5	PROFESSIONAL SERVICE CODE	S***R***	
441-E6	RESULT OF SERVICE CODE	S***R***	Required when needed to communicate DUR information. See “ProDUR” section in Provider Manual.
474-8E	DUR/PPS LEVEL OF EFFORT	S***R***	Required if segment used
475-J9	DUR CO-AGENT ID QUALIFIER	S***R***	Not Required - Captured if transmitted
476-H6	DUR CO-AGENT ID	S***R***	Not Required - Captured if transmitted

Pricing Segment – Mandatory			Required for B1 & B3 transactions
NCPDP Field	**Field Name**	**Mandatory or Situational**	**COMMENTS/VALUES**
111-AM	SEGMENT IDENTIFICATION	M	11
409-D9	INGREDIENT COST SUBMITTED	M	Required
412-DC	DISPENSING FEE SUBMITTED	S	Required
477-BE	PROFESSIONAL SERVICE FEE SUBMITTED	S	Not Required - Captured if transmitted
433-DX	PATIENT PAID AMOUNT SUBMITTED	S	Not Required - Captured if transmitted
438-E3	INCENTIVE AMOUNT SUBMITTED	S	Not Required - Captured if transmitted
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	S	Not Required - Captured if transmitted
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER	S***R***	Not Required - Captured if transmitted
480-H9	OTHER AMOUNT CLAIMED SUBMITTED	S***R***	Not Required - Captured if transmitted
481-HA	FLAT SALES TAX AMOUNT SUBMITTED	S	Not Required - Captured if transmitted
482-GE	PERCENTAGE SALES TAX AMOUNT SUBMITTED	S	Not Required - Captured if transmitted
483-HE	PERCENTAGE SALES TAX RATE SUBMITTED	S	Not Required - Captured if transmitted
484-JE	PERCENTAGE SALES TAX BASIS SUBMITTED	S	Not Required - Captured if transmitted
426-DQ	USUAL AND CUSTOMARY CHARGE	M	Required For Public Health Service entities, usual and customary charge is the ‘actual acquisition cost’
430-DU	GROSS AMOUNT DUE	M	Required
423-DN	BASIS OF COST DETERMINATION	S	Not Required - Captured if transmitted

Compound Segment – Situational			Segment is not required - Use is encouraged if applicable
NCPDP Field	**Field Name**	**Mandatory or Situational**	**COMMENTS/VALUES**
111-AM	SEGMENT IDENTIFICATION	M	10
450-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	M	Required 01 = Capsule 02 = Ointment 03 = Cream 04 = Suppository 05 = Powder 06 = Emulsion 07 = Liquid 10 = Tablet 11 = Solution 12 = Suspension 13 = Lotion 14 = Shampoo 15 = Elixir 16 = Syrup 17 = Lozenge 18 = Enema
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	M	1 = Each 2 = Grams 3 = Milliliters
452-EH	COMPOUND ROUTE OF ADMINISTRATION	M	00 = Not specified 01 = Buccal 02 = Dental 03 = Inhalation 04 = Injection 05 = Intraperitoneal 06 = Irrigation 07 = Mouth/throat 08 = Mucous membrane 09 = Nasal 10 = Ophthalmic 11 = Oral 12 = Other/Miscellaneous 13 = Otic 14 = Perfusion 15 = Rectal 16 = Sublingual 17 = Topical 18 = Transdermal 19 = Translingual 20 = Urethral 21 = Vaginal 22 = Enteral
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	M***R***	Count Of Compound Product ID's (NDC's)
488-RE	COMPOUND PRODUCT ID QUALIFIER	M***R***	03 = NDC
489-TE	COMPOUND PRODUCT ID	M***R***	11-Digit NDC
448-ED	COMPOUND INGREDIENT QUANTITY	M***R***	Required
449-EE	COMPOUND INGREDIENT DRUG COST	M	Required When A Compound Drug Is Dispensed
490-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	M	Required When A Compound Drug Is Dispensed

Prior Authorization Segment – *Segment NOT REQUIRED at this time; fields intentionally not listed.*	*Specifications may be provided at a later date.*

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2. General Information

Live Date:		October 1, 2008
Maximum prescriptions per transaction:		4
Technical assistance, help desk:	(Starting October 1, 2008)	(866) 434 5520
Clinical and Prior Authorization support:	(Starting October 1, 2008)	(866) 434 5524
SXC Health Solutions, Inc.	(Prior to October 1, 2008)	(480) 362-5227

Vendor certification required:	Yes (by switching company)
Pharmacy Registration with Payer Required:	Yes
Switch Support:	NDC, ENVOY, ERx, QS1

3. Other Information

Prescriber ID – a valid National Provider Identifier or DEA number is required for all claims.